

Valley Pain Centers

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Phoenix / Peoria / Scottsdale

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Please fax **patient demographics, imaging reports, insurance card, and relevant office notes** with this referral.

Patient Name: _____ Today's Date: _____ DOB: _____

Primary Phone: _____

Clinical History: _____

ICD-10 Code: _____ Diagnosis: _____

Insurance Co: _____ Insurance Phone #: _____

Policy #: _____ Group #: _____

Personal Injury? Y / N Case Mgr / Paralegal Name: _____

Attorney Name: _____ Attorney Phone #: _____

Work Comp? Y / N Adjuster / Case Mgr Name: _____

SERVICES OFFERED AT VPC

- MUA
- PRP / Amnion
- Synvisc
- Trigger Point / Myofascial Injects
- Spinal Cord Stim Trials / Implants
- Kyphoplasty
- All Joint Injections
- Epidural Injections
- Medial Branch Blocks
- Occipital Nerve Blocks
- Intercostal Nerve Blocks
- Radio Frequency Ablation
- Bursa / Tendon Injections
- Peripheral Nerve Blocks
- Piriformis Injections
- Median Nerve blocks
- Diagnostic Arthroscopy
- Botox
- Traumeel

PLEASE CIRCLE

Consult Only

Evaluate & Treat

Area of concern: Spine / Shoulder / Elbow / Wrist / Hand / SI / Hip / Knee / Ankle / Foot / Other

R L Bilateral Level _____

Comments: _____

Referring Physician: _____ Signature: _____
(Please Print)

Phone: _____ Fax: _____

Patient is scheduled for: _____ **Time:** _____